Section 1115 Demonstration Extension

Iowa Wellness Plan
Project #11-W-00289/5

State of Iowa
Department of Human Services

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Section I – Executive Summary

Iowa Department of Human Services (DHS) has a history of seeking to improve the State's Medicaid program, as well as beneficiary choice, accountability, quality of care, and health outcomes. On January 1, 2014, the State implemented the Iowa Wellness Plan (IWP) (Project #11-W-00289/5) §1115 Demonstration Waiver to provide access to healthcare for uninsured, low-income Iowans, while implementing a benefit design intended to address liabilities associated with simply expanding the number of members in traditional Medicaid coverage. During the initial waiver period, the innovative design of the IWP has demonstrated success in meeting key State goals. Members have been increasingly engaged in completing healthy behaviors including accessing preventive healthcare services. Additionally, members have improved access to providers under the waiver. Furthermore, the program has significantly increased enrollment, providing access to healthcare for an otherwise uninsured population. The State seeks to continue its success with the IWP and requests an extension of all current federal waivers and expenditure authorities, including the non-emergency medical transportation waiver (NEMT), which are set to expire December 31, 2016 and June 30, 2016, respectively. The requested extension period for all waivers is January 1, 2017 through December 31, 2019, pursuant to §1115(e) of the Social Security Act. No program changes are proposed.

Section II – History

Background

In 2013, the Iowa Legislature passed with bi-partisan support the Iowa Health and Wellness Plan (IHAWP) to provide access to healthcare for uninsured, low-income Iowans, using a benefit design intended to address liabilities associated with simply expanding the number of members in traditional Medicaid coverage. The IHAWP design sought to improve outcomes, increase personal responsibility, and ultimately lower costs. Key goals were to ensure the IHAWP population had access to high-quality local provider networks and modern benefits that worked to improve health outcomes; and to drive healthcare system transformation by encouraging a shift to value based payments that align with important developments in both the private insurance and Medicare markets.

The IHAWP sought to provide a comprehensive, commercial-like benefit plan that ensures provision of the Essential Health Benefits, indexed to the State Employee Plan benefits, with supplemental dental benefits similar to those provided on the Medicaid State Plan. Through a unique incentive program, the IHAWP also sought to promote responsible health care decisions by coupling a monthly required financial contribution with an incentive plan for members to actively seek preventive health services and earn an exemption from the monthly contribution requirement. Original IHAWP options included the following

1. The Iowa Wellness Plan (IWP), which covered adults ages 19 to 64, with household incomes at or below 100% of Federal Poverty Level (FPL); and
2. The Marketplace Choice Plan (MPC), which covered adults age 19 to 64, with household incomes of 101% through 133% of FPL.

On December 10, 2013, the Centers for Medicaid and Medicare Services (CMS) approved the Iowa Wellness Plan §1115 Demonstration Waiver (Project #11-W-00289/5) and the Marketplace Choice §1115 Demonstration Waiver (Project # 11-W-00288/5), thereby enabling the state to implement the IHAWP on January 1, 2014.

Iowa Medicaid originally administered the IWP through several delivery systems including independent primary care physicians (PCPs), accountable care organizations (ACOs), and managed care plans. Services provided by independent PCPs and ACOs were provided on a fee-for-service basis, while managed care plans were compensated based on capitation.

The MPC Demonstration allowed enrolled members to select from participating commercial health care coverage plans available through the Health Insurance Marketplace. Medicaid paid MPC member premiums and cost sharing to the commercial health plan on behalf of the member, and members had access to the network of local health care providers and hospitals served by the commercial insurance plan. Historically, members could elect to receive coverage through one of two qualified health plans (QHPs); however, there are no longer any QHPs available to serve the population, thereby eliminating coverage options for the MPC Demonstration. These members were subsequently enrolled in in the IWP demonstration, pursuant to the December 2015 amendment noted below.

Amendment History

Several amendments to the IHAWP waivers have been approved during the original demonstration period. On May 1, 2014, CMS approved the State's request to amend both the IWP and MPC Demonstrations to provide tiered dental benefits to all expansion adults in Iowa with incomes up to and including 133% of FPL through a Pre-Paid Ambulatory Health Plan ("PAHP"). This model was designed to promote and encourage healthy preventive care-seeking behaviors among members, and to ensure competitive reimbursement rates for providers and a reduction in administrative barriers. Core dental benefits included basic preventive and diagnostic, emergency, and stabilization services, implemented through the IWP and MPC alternative benefit plans (ABPs), while tiered "Enhanced," and "Enhanced Plus" earned benefits are provided to beneficiaries through the IWP and MPC demonstrations, based beneficiary completion of periodic exams.

In addition to the above amendment, CMS has twice approved the State's request to extend its waiver of the non-emergency medical transportation (NEMT) benefit from both the IWP and MPC Demonstrations. When CMS originally approved this authority, on January 1, 2014, it was scheduled to sunset on December 31, 2014, with the possibility of extending based on an evaluation of the impact on access to care. Initial experience demonstrated that lack of NEMT services was not significantly impeding IHAWP member access to care. In fact, from January to June 2014, 39% of members received at least one service and over 14% of members completed exams in the first eight months, as compared to an annualized figure of 6.5% for Medicaid overall. After reviewing initial data on the impact of the waiver on access, CMS approved an extension of the NEMT waiver through July 31, 2015. Thereafter, CMS and the State established criteria necessary for the State to continue the NEMT waiver beyond July 31, 2015. Specifically, the State agreed to compare survey responses of the IHAWP members to survey responses of persons receiving "traditional" Medicaid benefits through the State Plan. Iowa conducted the analysis and found that the survey responses of the two populations did not have statistically significant differences. In light of those results, CMS approved a second amendment through June 30, 2016, to allow more time to evaluate the impact of the NEMT waiver.

Most recently, on December 24, 2015, CMS approved the State's request to amend the IWP Demonstration to allow persons with incomes at or below 133% of FPL who were previously eligible for the MPC Demonstration to be eligible for the IWP Demonstration. This change had no impact on enrollment, benefits, enrollee rights, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, or other comparable program elements, and the transition of existing MPC Demonstration members into the IWP Demonstration took place on January 1, 2016. On February 23, 2016, CMS approved the State's request to implement a managed care delivery system for the IWP Demonstration, concurrent with the §1915(b) High Quality Healthcare Initiative Waiver, effective April 1, 2016.

Goals & Objectives

As noted above, key goals of the IHAWP are to ensure that Iowans have access to high-quality local provider networks and modern benefits that work to improve health outcomes; and to drive healthcare system transformation by encouraging a shift to value based payments that align with important developments in both the private insurance and Medicare markets. The State has successfully achieved these goals through the following objectives: (1) improving enrollee health and wellness through healthy behaviors and use of preventive services; (2) increasing enrollee engagement and accountability in their health care; and (3) increasing enrollee access to dental care. Each objective has specific metrics that to assess changes in outcomes, quality, access, and cost, many of which are highlighted and summarized in Sections V and VII below. The proposed extension will enable the State to continue its efforts, utilizing through the newly approved managed care delivery system, which is designed to deliver services in a highly coordinated manner and further incentivize active management of members' healthcare.

Section III – Program Changes

The State is not requesting any changes to the existing IWP Demonstration and seeks continuation of all waivers. A description of the IWP's current eligibility requirements, benefits, cost sharing requirements, and delivery system is provided below.

Eligibility

The IWP targets individuals who are eligible in the new adult group under the State Plan.

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
The Adult Group	§1902(a)(10)(A)(i)(VIII) 42 CFR §435.119	0 – 133% FPL

Benefits

IWP Core benefits are described in the Iowa Wellness Plan alternative benefit plan (ABP), except for enhanced benefits provided in the Dental Wellness Plan. IWP enrollees qualify for Enhanced or Enhanced Plus dental benefits earned through completion of periodic exam incentives. IWP enrollees will not receive any benefit in the form of an administrative activity or service to assure non-emergency transportation (NEMT) to and from providers.

Cost Sharing

All IWP members have no cost-sharing during their first year of enrollment. During the second year, enrollees at or above 50% of the FPL, who do not complete required healthy behaviors (i.e., health risk assessment and annual exam) during their first year of enrollment will be required to pay a monthly premium during the subsequent enrollment year, subject to a 30-day healthy behavior grace period. Individuals below 50% of the FPL, medically frail and members in the HIPP population, and all individuals who self-attest to a financial hardship are exempt from the required premium payment.

Monthly premium amounts will not exceed $5 per month for nonexempt households from 50% up to 100% of FPL, and $10 per month for nonexempt households between 100% and 133% of FPL. Enrollees are allowed a 90-day premium grace period, and enrollees under 100% FPL cannot be disenrolled for nonpayment of a premium, nor can an individual be denied an opportunity to re-enroll due to nonpayment of a premium. Individuals over 100% may be disenrolled for nonpayment but they can reapply. After 90 days, unpaid premiums may be considered a collectible debt owed to the State. Finally, the State may impose a copayment for non-emergency use of the emergency room consistent with Iowa's Medicaid State Plan and with all federal requirements.

Delivery System

Managed care organizations are responsible for delivering all IWP covered benefits, with the exception of dental benefits, which are carved out and delivered to Demonstration enrollees through a prepaid ambulatory health plan (PAHP).

Enrollment of Demonstration participants in managed care and the program is mandatory, with the exception of certain populations described in the the State's §1915(b) Iowa High Quality Healthcare Initiative Waiver, and Alaskan Natives and American Indians are enrolled voluntarily. Excepted populations continue to receive services through the fee-for-service delivery system outlined in Iowa's Medicaid State Plan.

Section IV – Authorities

Waiver Authority

The State requests continuation of the following waivers of state plan requirements contained in §1902 of the Act, subject to the STCs for the IWP §1115 Demonstration:

Premiums, Section 1902(a)(14) and Section 1916 – To enable the state to charge premiums beyond applicable Medicaid limits to the IWP Demonstration populations above 50 percent of the federal poverty level, with cost-sharing subject to a quarterly aggregate cap of 5 percent of family income.

Methods of Administration, Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53 – To the extent necessary to relieve the state of the responsibility to assure transportation to and from providers for individuals in the demonstration.

Comparability, Section 1902(a)(17) – Specifically, to permit the state to provide reduced cost sharing for the newly eligible population. This will be done through a $8 copay for non-emergency use of the emergency department. This copay will not apply to other Medicaid populations; copays applied to other Medicaid populations will not be imposed on this population.

Expenditure Authority

The State requests that expenditures made by the State for the items identified below, which are not otherwise included as expenditures under §1903, continue to be regarded as expenditures under the State's Title XIX plan:

Medically Frail – Expenditures for all of the cost of the payment for core dental benefits to medically frail in the state plan.

Dental – Expenditures for all of the cost of the payment of enhanced and enhanced plus dental tiers.

The State also requests that the following requirements remain not applicable to the expenditure authority:

Proper and Efficient Administration, Section 1902(a)(17) – To the extent necessary to permit the state to contract with a single dental benefit plan administrator to provide dental services to beneficiaries affected by the IWP §1115 Demonstration.

Freedom of Choice Section 1902(a)(23)(A) – To the extent necessary to permit the state to require enrollees to receive dental services through a carved-out contracted dental benefit with no access to other providers.

Section V – Reporting

Throughout 2014 and 2015, the State documented the progress of the demonstration in the form of quarterly and annual reports, available at http://dhs.iowa.gov/ime/about/initiatives/iowa-health-and-wellness-plan/ihawp-fed-docs. A summary of these reports is highlighted below.

1. *Total enrollment increased over 115%* between January 1, 2014 and December 31, 2015, and the State has received a very low number of issues or complaints (less than 1%) from members regarding access, services, or benefits.

2. *Compliance with access to care standards were met or exceeded* throughout 2014 and 2015. Provider surveys revealed at least 95% of beneficiaries reside in counties with providers that meet all timely access to care standards. Additionally, at *least 90% of members reside in counties with providers that meet National Committee for Quality Assurance (NCQA) standards*.

3. Member *outreach activities have been consistent in meeting the demands of member engagement to ensure eligible individuals have access to services*. Throughout 2014 and 2015, member outreach included informational packets, in-person educational sessions, and the creation of a Customer Contact Center to assist members with the enrollment process.

4. The *State has successfully introduced an incentive program designed to engage members in healthy behavior activities*. Since the inception of the program an average of over 50% of members with incomes 50% to 133% of FPL have successfully completed two required healthy behaviors based on data obtained from the State's Medicaid Management Information System (i.e., a health risk assessment (HRA) and a wellness exam).

5. A recent member survey revealed that beneficiaries had positive perceptions of getting a wellness exam and completing an HRA. There was a consensus among members that required healthy behavior activities would improve their health.

6. Over *65,000 IHAWP members have received services through the Dental Wellness Plan* during 2014 and 2015. Of these members, 97% of members received a diagnosis and preventive service, 44.5% received a stabilization service, and 32.6% received an emergent service.

7. The *dental provider network has increased*, which has improved members' access to care. Currently 99.8% of members reside no more than thirty miles from a provider.

In addition to the quarterly and annual reports, the State has conducted multiple studies regarding the impact of the NEMT waiver. In 2014, the University of Iowa Public Policy Center researched if there were differences in the access to care for IHAWP members for whom non-emergent transportation services were waived and the traditional Iowa Medicaid State Plan, whose members receive non-emergent transportation services. The study consisted of responses

to member surveys and a network analysis to assess travel distance to available providers. These analyses indicated that there was little, if any, difference in the barriers to care for IHAWP versus Medicaid members as a result of transportation-related issues as assessed in the surveys. Key findings include:

1. The majority of respondents of both groups drive themselves (77% Medicaid, 68% IHAWP) or are driven by family or friends (17% Medicaid, 22% IHAWP) to their health care appointments.
2. There was no difference between Medicaid and IHAWP in the reporting of not having a reliable method to get to health care visits with around 2% reporting no reliable transportation.
3. Overall, around 20% of Medicaid and IHAWP members reported usually or always needing help from others to get to a health care visit.
4. Around 13% of both Medicaid and IHAWP enrollees reported an unmet need for transportation to or from a health care visit in the six months prior to the survey.
5. Overall, less than 10% of members reported ever having used the Medicaid transportation benefit (8% of Medicaid enrollees and 4% of IHAWP).
6. There was no difference between Medicaid and IHAWP in reported worry about the cost of transportation.
7. IHAWP enrollees were asked the following question: "Do you think the care you received at your most recent visit to the ER could have been provided in a doctor's office if one was available at the time? If so, what was the main reason you did not go to a doctor's office or clinic for this care?"
    a. Of those surveyed who indicated they could have received care in a doctor's office, the majority reported using the ER instead because the doctor's office or clinic was not open when they needed care (63%). Only 2% reported they went to the ER due to transportation problems.
8. Transportation difficulties were the sixth most reported barrier to obtaining a physical exam with only 6% reporting this issue.

Following this initial survey, the Public Policy Center fielded a survey to over 30,000 IHAWP and Medicaid members from October 28, 2015 – January 15, 2016. Key findings included:

1. State Plan enrollees who have access to the NEMT benefit have a higher unmet NEMT need than waiver enrollees.
2. Medicaid enrollees who reported an unmet need for routine care reported transportation as the reason for being unable to access care despite having the Medicaid NEMT benefit. Specifically, among surveyed Medicaid members with an unmet need for routine care, the reasons for not getting care included: 30% reported that the wait was too long, 17% reported not being able to get transportation to the doctor, and 10% reported not being able to afford the care, the health plan would not approve/ pay for the care, or they could not get time off work/get child care. For those in the Wellness Plan with an unmet need for routine care, 23% were not able to get transportation, 17% reported that the wait was too long, and 15% reported that the health plan would not approve/pay for the care.
3. The top 3 reasons for members accessing the ER versus primary care setting were the same among Medicaid and IHAWP enrollees. The doctor's office not being open when

care was needed was the most cited reason for using the ED instead of a clinic, followed by a health problem that was too serious for the doctor's office or clinic, and being advised by a doctor, nurse, or other health care provider to go to the ED for care. Of note, having transportation problems getting to a doctor's office or clinic was chosen by 3% of both Medicaid and Wellness Plan enrollees.

4. A statistically significant higher percentage of Medicaid enrollees reported having an unmet need for transportation to health care visits than Wellness Plan enrollees (16% versus 13%).
5. As in the 2014 survey, the level of worry about the ability to pay for the cost of transportation to or from health care visits was comparable between Medicaid and Wellness Plan members.
6. The majority of both Medicaid and Wellness Plan enrollees reported that they drove themselves using their own vehicle to get to their appointments (Medicaid: 69%, Wellness Plan: 58%). Only 1% of Medicaid enrollees and Wellness Plan enrollees reported having no reliable way to get to health care visits.
7. The evaluators noted "At first glance, these results on health care utilization (particularly with regard to well care visits), coupled with the fact that Wellness Plan members self-report worse health, may suggest that having an unmet need for NEMT and not having the NEMT benefit (i.e., being in the Wellness Plan) leads to members in need of care not being able to obtain care. However, it is worth pointing out that those with the benefit (Medicaid State Plan) experienced more unmet NEMT need than those in the Wellness Plan. Therefore, without considering the experiences surrounding why individuals have an unmet NEMT need in more detail, it could be premature to reach that conclusion."

Section VI – Financing

Historic and projected average monthly eligibility is as follows, by Demonstration Year (DY):

IWP Demonstration	DY1	DY2	DY3	DY4	DY5	DY6
Average Monthly Eligibility	98,681	136,824	158,170	161,333	164,560	167,851

DY1 and DY2 estimates were developed by summarizing historical enrollment for individuals with a recipient program code of 501 (Wellness Plan) and any benefit plan indicator or recipient program code 531 (Marketplace Choice) and benefit plan indicator of 'W' (Wellness Plan).

DY3 through DY6 estimates were developed by projecting the combined Wellness and Marketplace Choice populations (all individuals with a recipient program code of 501 or 531) enrolled December 2015 (using data through February 2016) using an annualized trend rate of 2%. We included the Marketplace Choice population in this projection since it was transitioned to the Wellness population as of January 1, 2016.

The table below illustrates the estimated DY4 through DY6 IWP Demonstration budget neutrality including enrolled member months, per member per month (PMPM) cost per enrollee, and total state and federal expenditures:

IWP Demonstration	DY4	DY5	DY6
Member Months	1,693,544	1,727,415	1,761,963
Dental PMPM	$28.34	$29.67	$31.06
Dental Expenditures	$47,995,037	$51,252,403	$54,726,571

Pending approval of the IWP Demonstration extension, the values noted above will represent the IWP Demonstration budget neutrality limit. The State and its vendors will be required to manage the costs of the waiver to be less than the budget limit on a PMPM basis over the full extension period.

Please see the attached documents prepared by Milliman, Inc. describing in detail annual aggregate expenditures, including historic enrollment and budgetary data.

Section VII – Evaluation Report

Evaluation Demonstration Activities

In December of 2015, an interim evaluation report of the IHAWP was completed by the University of Iowa Public Policy Center. As described in further detail below, the evaluation revealed numerous key positive findings related to access, quality, and cost. The evaluation design was approved by CMS to study the following questions:

1. What are the effects of the waiver on member access to care?
2. What are the effects of the waiver on member insurance coverage gaps and insurance services when their eligibility status changes (churning)?
3. What are the effects of the waiver on member quality of care?
4. What are the effects of the waiver on the costs of providing care?
5. What are the effects of the premium incentive and copayment disincentive programs on waiver enrollees?
6. What is the adequacy of the provider network for waiver enrollees as compared to those in the Iowa Medicaid State Plan?
7. Is the presence or absence of the NEMT benefit associated with unmet need for transportation to health care visits?

Additionally, in March of 2016, the University of Iowa Public Policy Center completed an interim evaluation report of the Dental Wellness Plan. The evaluation studied the following questions:

1. What are the effects of the Dental Wellness Plan on member access to care?
2. What are the effects of the Dental Wellness Plan on member quality of care?
3. What are the effects of the Dental Wellness Plan on costs of dental care as compared to traditional Medicaid dental coverage?
4. What are the effects of the earned benefit structure on Dental Wellness Plan members?
5. What is the adequacy of the provider network for Dental Wellness Plan members?
6. What are provider attitudes toward the Dental Wellness Plan?
7. What are the effects of Dental Wellness Plan member outreach and referral services?

Full interim evaluation reports are available on a dedicated Department of Human Services (DHS) website at http://dhs.iowa.gov/ime/about/initiatives/iowa-health-and-wellness-plan/ihawp-fed-docs. The section below is intended to provide a high level summary of key findings for each study question.

Evaluation Findings to Date

Access to Care

The evaluation report revealed several key positive findings related to member access to care as highlighted below.

1. Waiver enrollees were more likely to have had a preventive/ambulatory care visit than during enrollment in IowaCare, the program which the Wellness Plan replaced.
2. The majority of waiver enrollees (81%) reported usually or always having access to urgent care services when needed.
3. Access to routine care was statistically significantly higher for waiver enrollees than low income adults enrolled in Medicaid State Plan coverage.
4. The majority of waiver enrollees (70%) reported usually or always experiencing timely access to care and information.
5. Of those waiver enrollees reporting a time when they thought they needed care from a specialist, the majority (82%) reported that they usually or always got an appointment as soon as they needed.
6. The vast majority of waiver enrollees (87%) reported the most ease in getting prescription medications.
7. Rates of breast cancer screening were higher among women enrolled in the Wellness Plan (53%) compared to State Plan populations (45%).
8. Waiver enrollees with diabetes were more likely to have a Hemoglobin A1c than State Plan populations (87% versus 75%).
9. Waiver enrollees had a significantly higher rate of preventive care visits than Medicaid State Plan enrollees eligible due to income (60% versus 48%).
10. Members with a major depressive disorder were much more likely to receive effective acute phase and continuation phase treatment than State Plan enrollees (49% versus 27%).
11. Rates of emergency department visits (ED) and follow-up ED visits were lower for waiver enrollees than State Plan enrollees.

Churn

The interim evaluation looked at the impact of the waiver on member churn, which is member movement between Medicaid programs and qualified health plans as their eligibility changes. As highlighted below, the waiver provided health coverage to individuals that would have otherwise lacked access in the absence of the Health and Wellness Plan.

1. 17,382 members switched 17,778 times upward, moving from State Plan to either Wellness Plan or Marketplace Choice Plan coverage or Wellness Plan to Marketplace Choice Plan, retaining coverage that would not have been possible without the Health and Wellness Plan.
2. More waiver enrollees had positive churn than State Plan enrollees. Positive churn is described as movement into another program as income increases.
3. The majority of waiver enrollees (81%) reported having a regular sources of care (i.e., personal doctor). This was higher than reported under the State's former IowaCare program (67%).

Quality of Care

As identified in the full interim evaluation report, several protocols studying quality are under development for the final evaluation report. However, initial findings, as highlighted below, indicate positive results for waiver enrollees.

1. A statistically higher percentage of waiver enrollees reported receiving a flu shot compared to low income adults enrolled in State Plan coverage.
2. The percentage of potentially avoidable emergency department use was statistically lower among waiver enrollees than low income adults enrolled in State Plan coverage (51% versus 71%).
3. Waiver enrollees had a statistically lower hospital admission rate (11%) than low income adults enrolled in State Plan coverage (16%).
4. The vast majority of waiver enrollees (88%) reported usually or always having good communication with their provider.
5. There were significant differences between waiver enrollees and low income State Plan enrollees in satisfaction with all of the health care received with more waiver enrollees reporting high satisfaction.

Cost

Incremental cost effectiveness measures will be provided in the final evaluation report. However, findings on the measure reviewed in the interim evaluation were positive; as highlighted below, per member per month (PMPM) costs for Wellness Plan enrollees were lower than those in the Medicaid State Plan.

1. In comparing Wellness Plan per member per month (PMPM) cost and use to State Plan enrollee PMPM cost and use, the ED and prescription medicine PMPM cost and use are all significantly less.

Premiums and Cost Sharing/Healthy Behaviors

1. Rates of well care visits were higher for waiver enrollees versus State Plan enrollees.
2. The majority of Wellness Plan enrollees reported it would be “very easy” to obtain a physical exam (62%), a healthy behavior eligible for waiving the premium obligation.
3. Increased awareness of the program appears to be needed. The recent implementation of managed care for the Wellness Plan population provides a key opportunity for the State to work in partnership with these organizations charged with member outreach to better assure program awareness and understanding.

Provider Network Adequacy

The interim evaluation indicates enrollees have access to care near their homes.

1. Waiver enrollees lived a mean of 2.4 miles from the nearest PCP.
2. The majority of members (98%) lived less than 30 minutes from the nearest PCP.

NEMT Experience

The State has conducted multiple studies of the impact of the NEMT waiver on enrollees. As described in further detail in Section V, Reporting, findings indicate Medicaid enrollees who have NEMT coverage through the State Plan actually have a *higher* unmet NEMT need than waiver enrollees.

Dental Wellness Plan

As described in the Dental Wellness Plan interim evaluation report, for some dental-related measures, data was unavailable as insufficient time had passed since the beginning of the waiver period for the specific measure. However, as highlighted below, available data indicates waiver enrollees have access to dental services.

1. The majority of surveyed waiver enrollees (76%) needing emergency dental care in a dental office reported being able to see a dentist as soon as they wanted.
2. The majority of surveyed waiver enrollees (57%) utilized dental care from a source other than the emergency department at least once since joining the plan.
3. The majority of waiver enrollees (69%) reported "usually" or "always" being able to obtain a routine dental appointment in a timely manner.
4. Surveyed waiver enrollees reported having a regular dentist who accepts their dental plan at a higher rate than prior to their enrollment in the Dental Wellness Plan (35% pre-enrollment and 53% post-enrollment).
5. Receipt of routine dental exams was higher among Dental Wellness Plan members than Medicaid State Plan enrollees (31% versus 23%).
6. The vast majority (94%) off surveyed enrollees who indicated they had used information from their dental plan to find a new dentist indicated it was "very easy" or "somewhat easy" to change to a new dentist in the Dental Wellness Plan. This is compared to only 50% of Medicaid State Plan enrollees.
7. The majority of surveyed participating dentists were either "satisfied" or "very satisfied" with the Dental Wellness Plan (63%).

Evaluation Plan for Extension Period

The State intends to continue studying the following questions and hypotheses during the waiver extension period. The State is working closely with the evaluation vendor to assess the extent to which the implementation of statewide managed care effective April 1, 2016 will impact the evaluation design during the extension period in regards to the study population and comparison groups. Additionally, as noted in the interim evaluation report, there were some measures for which sample size limitations prevented use of the original proposed analytic method. The State will continue to work with the evaluation vendor to finalize the analytic method for each hypothesis for the final extension evaluation design.

Table 1: Evaluation Questions & Hypotheses

Question	Hypotheses
Question 1: What are the effects of the Wellness Plan on member access to care?	Hypothesis 1.1: Wellness Plan members will have equal or greater access to primary care and specialty services.
	Hypothesis 1.2: Wellness Plan members will have equal or greater access to preventive care services.
	Hypothesis 1.3: Wellness Plan members will have equal or greater access to mental and behavioral health services.
	Hypothesis 1.4: Wellness Plan members will have equal or greater access to care, resulting in equal or lower use of emergency department services for non-emergent care.
	Hypothesis 1.5: Wellness Plan members without a non-emergency transportation benefit will have equal or lower barriers to care resulting from lack of transportation.
	Hypothesis 1.6: Wellness Plan members ages 19-20 years will have equal or greater access to EPSDT services.
Question 2: What are the effects of the Wellness plan on member insurance coverage gaps and insurance service when their eligibility status changes (churning)?	Hypothesis 2.1: Wellness Plan members will experience equal or less churning.
	Hypothesis 2.2: Wellness Plan members will maintain continuous access to a regular source of care when their eligibility status changes.
Question 3: What are the effects of the Wellness Plan on member quality of care?	Hypothesis 3.1: Wellness Plan members will have equal or better quality of care.
	Hypothesis 3.2: Wellness Plan members will have equal or lower rates of hospital admissions.
	Hypothesis 3.3: Wellness Plan members will report equal or greater satisfaction with the care provided.
Question 4: What are the effects of the Wellness Plan on the costs of providing care?	Hypothesis 4.1: The cost for covering Wellness Plan members will be comparable to the predicted costs for covering the same expansion group in the Medicaid State Plan.

Question	Hypotheses
Question 5: What are the effects of the premium incentive and copayment disincentive programs on Wellness Plan enrollees?	Hypothesis 5.1: The premium incentive for the Wellness Plan enrollees will not impact the ability to receive health care.
	Hypothesis 5.2: The copayment for inappropriate emergency department (ED) use for the Wellness Plan enrollees will not pose an access to care barrier.
	Hypothesis 5.3: In year two and beyond, the utilization of an annual exam will be higher than in the first year of the renewal period.
	Hypothesis 5.4: In year two and beyond, the utilization of smoking cessation services will be higher than in the first year of the renewal period.
Question 6: What is the adequacy of the provider network for Wellness Plan enrollees as compared to those in the Iowa Medicaid State Plan?	Hypothesis 6.1: Iowa Wellness Plan members will have the same access to an adequate provider network as members in the Medicaid State Plan.

Section VIII – Public Notice

The following is intended to documentation of the State's compliance with the public notice process set forth in 42 CFR §431.408, including the post-award public input process described in 42 CFR §431.420(c). In it's final submission to CMS, the state will include a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

Public Notice Process

The public has an opportunity to comment on this extension waiver through a public notice and comment process. Public notice was provided on April 12, 2016. This notice and all waiver documents were posted on a dedicated Department of Human Services (DHS) website at http://dhs.iowa.gov/ime/about/initiatives/iowa-health-and-wellness-plan/ihawp-fed-docs. To reach all stakeholders, non-electronic copies were made available for review at DHS Field Offices. In addition, a summary notice was published in several newspapers with statewide circulation and DHS sent an email notice to nearly 3,000 stakeholders. All notices provided the option for individuals to submit written feedback to the State by email or by U.S. Postal Service mail. Comments are accepted electronically through a dedicated email address and in person. Finally, the State will hold two public hearings to offer an opportunity for the public to provide written or verbal comments about the extension waiver. Hearings will be held at on April 19, 2016, in Des Moines, Iowa (Executive Committee of the Iowa Medical Care Advisory Committee that operates in accordance with 42 CFR §431.12), and May 10, 2016 in Fort Dodge, Iowa (open forum for interested parties to learn about the contents of the extension application, and to comment on its contents). Hearings will be held in two geographically distinct areas of the State. The public comment period is scheduled to end May 12, 2016, at which time all comments will be cataloged, summarized, and organized.

Post-Award Forums

In accordance with the IWP Special Terms and Conditions, the State held an open forum on May 21, 2014, to allow the public an opportunity to comment on the progress of the Demonstration. The majority of the participants asked for clarification of specific program components including the Dental Wellness Plan, the Healthy Behaviors Program, monthly contributions, Medically Exempt status, and the IWP provider network. Post-award forum meeting minutes and written comments are available online at http://dhs.iowa.gov/sites/default/files/IMCP.Q2.pdf. On May 28, 2015, a second forum was held during the Iowa Medical Assistance Advisory Committee to allow interested parties learn about the progress of the IHAWP. Agenda, minutes, and materials from this forum may be found online at https://dhs.iowa.gov/ime/about/advisory_groups/maac/maac_archives.

Tribal Consultation Process

DHS initiated consultation with with Iowa's federally recognized Indian tribes, Indian health programs, and urban Indian health organizations on March 14, 2016. Consultation is being conducted in accordance with the process outlined in Iowa's Medicaid State Plan, and consists of

an electronic notice directed to Indian Health Service/Tribal/Urban Indian Health (I/T/U) Tribal Leaders and Tribal Medical Directors identified by the Iowa Indian Health Services Liaison.

Iowa Wellness Plan 1115 Waiver Budget Neutrality Documentation

Demonstration Years 1 through 6

State of Iowa

Department of Human Services

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April 12, 2016

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EXECUTIVE SUMMARY

Milliman, Inc. (Milliman) has been retained by the State of Iowa, Department of Human Services, to provide support in the submission of the Iowa Wellness Plan 1115 waiver renewal (number 11-W-00289/5). The waiver renewal period covers demonstration years (DY) four through six, or calendar year 2017 through calendar year 2019. This report provides budget neutrality information for the Iowa Dental Wellness Plan (IDWP) required for the waiver renewal.

Table 1 illustrates the estimated DY 4 through DY 6 IDWP enrolled member months, per member per month (PMPM) cost per enrollee, and total expenditures.

Table 1
State of Iowa, Department of Human Services
Iowa Dental Wellness Plan Budget Neutrality

Wellness Plan	DY 4	DY 5	DY 6
Member Months	1,693,544	1,727,415	1,761,963
Dental PMPM	$ 28.34	$ 29.67	$ 31.06
Dental Expenditures	$ 47,995,037	$ 51,252,403	$ 54,726,571

Pending approval from CMS, the PMPM values illustrated in Table 1 will be the IDWP budget neutrality limit. The state and its vendors will be required to manage the costs of the IDWP program to be less than the budget limit on a PMPM basis over the full renewal period. The state is not at risk for the number of enrollees in the demonstration. The special terms and conditions (STCs) provided by CMS outline the full contract terms.

Certain assumptions used in the development of the budget neutrality estimates in this report are subject to change. We may update this report when the following items are finalized:

- We used a trend of 4.7% to estimate the July through December 2016 with waiver PMPM costs and the DY 4 through DY 6 without waiver PMPM costs. Our understanding is 4.7% was the president's budget trend provided by CMS for the initial Iowa Wellness Plan 1115 waiver submission. We anticipate updating this trend estimate when we receive the current president's budget trend from CMS.

- The state fiscal year (SFY) 2016 IDWP capitation rate of $25.86 is still being discussed by the state and their vendor. To the extent the final SFY 2016 IDWP capitation rate is not $25.86, we will modify this report.

- The with waiver DY 3 member months and PMPM costs were used as the baseline for estimating the DY 4 through DY 6 member months and PMPM costs. DY 3 is not complete at this time. If the actual DY 3 member months and PMPM costs materially differ from the estimates included in this report, then the DY 4 through DY 6 estimates may need to be modified.

Additionally, please note that the illustrated member months throughout this report reflect the estimated number of dental capitation payments rather than actual Wellness Plan enrollment. Using the estimated capitation payments as an enrollment base allows the cost per enrollee amount to reflect the cost of individuals actually receiving dental services.

Appendix A illustrates the estimated member months, dental PMPM cost, and total dental expenditures for the wellness population with the approval of the 1115 waiver for DY 1 though DY 6. This appendix corresponds to the "Demonstration With Waiver (WW) Budget Projection" tab of the CMS 1115 Waiver Budget Neutrality workbook.

Appendix B illustrates the estimated member months, dental PMPM cost, and total dental expenditures for the wellness population without the 1115 waiver for DY 1 though DY 6. This appendix corresponds to the "Demonstration Without Waiver (WOW) Budget Projection" tab of the CMS 1115 Waiver Budget Neutrality workbook.

Appendix C illustrates the estimated savings of the Wellness Plan 1115 waiver by comparing the PMPM and expenditure amounts in Appendix A and Appendix B.

METHODOLOGY

This section of the report outlines methodology used in estimating the DY 1 through 6 with and without waiver enrollment, PMPM cost, and total expenditures.

Enrollment

The first step of developing 1115 waiver budget neutrality projections is to identify the population included in the waiver. Individuals enrolled in the Wellness Plan may have periods of eligibility without a corresponding IDWP capitation payment because of retroactive enrollment or reinstatement periods where the dental premium was not paid. We utilized a methodology for illustrating enrollment that reflects the estimated capitation payments rather than the actual Wellness Plan enrollment. Using the estimated capitation payments as an enrollment base allows the cost per enrollee amount to reflect the cost of individuals actually receiving dental services. Our understanding is this methodology is consistent with budget neutrality calculations for other Iowa 1115 waivers.

We calculated DY 1 and DY 2 Wellness Plan enrollment by dividing the expenditures illustrated in Schedule C to the CMS-64 by the currently paid IDWP capitated rate of $22.66. Our understanding is the expenditures illustrated in Schedule C are on an incurred basis and do not contain any expenditures outside of the capitation payments paid to the IDWP vendor.

The DY 3 enrollment was estimated by trending the number of December 2015 IDWP capitation payments through CY 2016 using an annualized trend rate of 2%. Both IDWP capitation payments for Wellness Plan and Marketplace Choice Plan individuals were included in the December 2015 baseline. Although Marketplace Choice Plan individuals were not included in the wellness population for DY 1 or DY 2, our understanding is that all individuals enrolled in the Marketplace Choice Plan are included in the Wellness Plan effective January 1, 2016.

DY 4 through DY 6 enrollment was estimated by increasing the DY03 enrollment by 2% per year. We utilized a 2% enrollment trend based an expectation that enrollment growth will slow as the program matures. The state is not at risk for the number of enrollees in the demonstration.

Cost per Enrollee and Total Expenditures

With Waiver

The cost per enrollee values for the with waiver scenario in DY 1 through DY 3 were developed using the May 2014 to June 2015 capitated rate of $22.66, the draft SFY 2016 capitated rate of $25.86, and a rate of $27.08 for the remainder of DY 3 (July through December 2016). We increased the SFY 2016 capitation rates of $25.86 by 4.7% (the president's budget trend in the initial waiver filing) to develop the July through December 2016 capitation rate of $27.08. The SFY per enrollee costs were converted to a DY (or CY) basis using estimated enrollment in the Wellness Plan.

Additionally, the state provided the DY 1 through Q3 DY 2 supplemental FQHC / RHC payment expenditures. We added these historical expenditures to the cost per enrollee amounts, and we estimated the DY 2 Q4 wrap expenditures to be the average of DY2 Q1 through Q3 payments on a PMPM basis. DY 3 wrap payment expenditures were estimated to be the same as DY 2 expenditures on a PMPM basis.

If the final SFY 2016 capitation rate agreed upon between DHS and their vendor is not the draft rate of $25.86, then the budget neutrality workbook will need to be modified. Additionally, we will modify the trended values to the extent CMS provides a president's budget trend different than 4.7%.

The cost per enrollee "with waiver" values for DY 4 through DY 6 were developed by applying a 3.0% trend to the DY 3 with waiver cost per enrollee amount. The reduction in trend reflects expected savings to be achieved through the waiver program. The trended with waiver values will be replaced with actual experience in the budget neutrality workbook as it emerges.

Total expenditure amounts are developed using the estimated cost per enrollee and enrollment.

Without Waiver

The cost per enrollee information from the initial Iowa Wellness Plan 1115 waiver STCs was utilized for the "without waiver" scenario in DY 1 to DY 3. These amounts were agreed upon by CMS and the state and cannot be changed without a waiver amendment.

The cost per enrollee values for DY 4 to DY 6 were developed by applying a 4.7% trend to the DY 3 with waiver cost per enrollee amount. Recent CMS guidance states that the without waiver cost per enrollee should be rebased using actual expenditures from the prior waiver period.

We utilized a 4.7% without waiver trend assumption, which is consistent with the initial Wellness Plan 1115 waiver submission. Our understanding is the 4.7% trend was based on the president's budget trend at the time of the initial submission. Our expectation is that we will utilize the current president's budget trend for the Wellness Plan 1115 renewal when it is provided by CMS.

Total expenditure amounts are developed using the estimated cost per enrollee and enrollment.

LIMITATIONS AND DATA RELIANCE

The services provided for this project were performed under the contract between Milliman and State of Iowa dated July 17, 2014 and amended January 26, 2015.

The information contained in this report has been prepared for DHS and their consultants and advisors. It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this report is provided to third parties, it should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for DHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the results presented in this report. Any user of the values and information contained herein should have access to the entire report.

The 1115 waiver budget neutrality estimates are based on a projection of future events. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The author of this report is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this report.

We relied upon certain information provided by DHS. This includes the IDWP capitation payment data, Schedule C to the CMS-64, the STCs for the initial Wellness Plan 1115 waiver filing. We have relied upon DHS for the accuracy of the information provided. Although the data were reviewed for reasonableness, we have accepted the data without audit. To the extent the data provided to Milliman was incomplete or was otherwise inaccurate, the information presented in this report will need to be modified.

APPENDIX A: DEMONSTRATION WITH WAIVER BUDGET PROJECTION

Iowa DHS
Iowa Wellness Plan
1115 Waiver Budget Neutrality Estimates

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

ELIGIBILITY GROUP	TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	TOTAL DY 01 - DY 03	TREND RATE	DEMONSTRATION YEARS (DY) DY 04	DY 05	DY 06	TOTAL DY 04 - DY 06
Iowa Wellness Plan										
Member Months	2.0%	782,649	1,496,670	1,660,337	3,939,656	2.0%	1,693,544	1,727,415	1,761,963	5,182,922
PMPM	4.7%	$ 23.13	$ 24.92	$ 27.07	$ 25.47	3.0%	$ 27.88	$ 28.72	$ 29.58	$ 28.74
Expenditures	N/A	$ 18,102,671	$ 37,297,016	$ 44,945,323	$ 100,345,010	N/A	$ 47,216,007	$ 49,611,359	$ 52,118,866	$ 148,946,231

APPENDIX B: DEMONSTRATION WITHOUT WAIVER BUDGET PROJECTION

Iowa DHS
Iowa Wellness Plan
1115 Waiver Budget Neutrality Estimates

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

ELIGIBILITY GROUP	TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	TOTAL DY 01 - DY 03	TREND RATE	DEMONSTRATION YEARS (DY) DY 04	DY 05	DY 06	TOTAL DY 04 - DY 06
Iowa Wellness Plan										
Member Months	2.0%	782,649	1,496,670	1,660,337	3,939,656	2.0%	1,693,544	1,727,415	1,761,963	5,182,922
PMPM	4.7%	$ 24.71	$ 25.87	$ 27.09	$ 26.15	4.7%	$ 28.34	$ 29.67	$ 31.06	$ 29.71
Expenditures	N/A	$ 19,339,257	$ 38,718,853	$ 44,978,529	$ 103,036,639	N/A	$ 47,995,037	$ 51,252,403	$ 54,726,571	$ 153,974,011

APPENDIX C: ESTIMATED DEMONSTRATION SAVINGS

Iowa DHS
Iowa Wellness Plan
1115 Waiver Budget Neutrality Estimates

	Without Waiver							
Wellness Plan	**DY 01**	**DY 02**	**DY 03**	**DY 01-03**	**DY 04**	**DY 05**	**DY 06**	**DY 04-06**
Member Months	782,649	1,496,670	1,660,337	3,939,656	1,693,544	1,727,415	1,761,963	5,182,922
Dental PMPM	$ 24.71	$ 25.87	$ 27.09	$ 26.15	$ 28.34	$ 29.67	$ 31.06	$ 29.71
Dental Expenditures	$ 19,339,257	$ 38,718,853	$ 44,978,529	$ 103,036,639	$ 47,995,037	$ 51,252,403	$ 54,726,571	$ 153,974,011
	With Waiver							
Member Months	782,649	1,496,670	1,660,337	3,939,656	1,693,544	1,727,415	1,761,963	5,182,922
Dental PMPM	$ 23.13	$ 24.92	$ 27.07	$ 25.47	$ 27.88	$ 28.72	$ 29.58	$ 28.74
Dental Expenditures	$ 18,102,671	$ 37,297,016	$ 44,945,323	$ 100,345,010	$ 47,216,007	$ 49,611,359	$ 52,118,866	$ 148,946,231
	Estimated Waiver Savings / (Cost)							
Dental PMPM	$ 1.58	$ 0.95	$ 0.02	$ 0.68	$ 0.46	$ 0.95	$ 1.48	$ 0.97
Dental Expenditures	$ 1,236,585	$ 1,421,837	$ 33,207	$ 2,691,629	$ 779,030	$ 1,641,044	$ 2,607,705	$ 5,027,780